RESPONSIVENESS OF HEALTH SYSTEMS: A BAROMETER OF THE QUALITY OF HEALTH SERVICES

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Abstract

In the health field, quality is a complex and multidimensional variable. The complexity is shown by different levels of quality, which provide a global picture of the performance of a health system: compliance with mandatory rules, compliance with professional recommendations/references, action of steady improvement aiming at resolving health problems, risk management or excellence seeking, etc. The multidimensional character is provided by various dimensions to be covered by evaluation indicators of the performance of a health system: acceptability → in what points the health system meets our expectations; accessibility → knowing whether we can receive the services where and when we need them; adequacy → knowing whether the care meets our needs and is based on established rules; competence → knowing whether knowledge and skills of health services providers are consistent with the care they provide; continuity → matching services – coordination, integration, easy access; effectiveness → concerning the services in operation and in what point they influence our health; efficiency → achieving best results at the lowest cost; security → minimizing possible risks in a health area or service. Out of these dimensions – which, from a synergetic perspective, define the overall performance of a health system – we retain for a detailed analysis only those concerning acceptability, adequacy and competence, which determine the responsiveness to the patients' expectations.

Moreover, for working out a methodology for assessing the quality of health services, it is necessary to analyse various standard procedures for assessing the performance of health services initiated and rendered by international organisations and promoted, first of all, by the World Health Organisation. Our paper also deals with actions already taken worldwide, which now are undergoing structural improvements as well as with opportunities for making market surveys (opinion polls) among the beneficiaries of a health system: the citizens.

Keywords: health system; health system responsiveness; health system performance; health condition; determinants of health condition

JEL Classification: I11, I18

Introduction

The paper is mainly aimed at presenting a way of assessing the indicators that define one of the three fundamental ("intrinsic") objectives of health systems, namely, their responsiveness, that is, their capability to meet the population's expectations in fields other than those concerning the improvement of patients' health proper. It is a new concept formulated by the World Health Organisation (WHO), integrated into the assessment model of the performance of health systems, used for computing the overall performance indicator of health systems pertaining to WHO member countries, on which the country ranking is based. According to this ranking, Romania's place is not quite acceptable: it is ranked the 99th among 191 countries reporting to the WHO (2000, Table 10 in Annex, p. 222). This ranking of our country require a detailed analysis of the set of indicators proposed by the WHO methodology and the identification of the weaknesses of the Romanian health system. This is the problem we try to clarify – only that the purpose of our research is only knowing the responsiveness of the Romanian Health system to the patients' expectations, in accordance with data collected through the opinion poll among a sample of patients from representative health units located in six districts. But in an important area – a national health system – performance is multidimensional, which requires defining a set of indicators for reflecting the size of this performance. Also, at the beginning of this paper, it is necessary to define the concept and the significance of the health system, as well as the concept of quality and equity, as a reason for improving the performance of health systems.

1. The health system: Concept and significance

A critical problem of health care is the definition of the term "health condition". The western health care model defines health as "the absence of a disease or illness of any kind" (H.R. Blank, V. Burau, 2004, 52). According to this definition, people are healthy if they not suffer from a mild or serious disease. Curing medicine is a model according to which health is basically an ability to adapt to problems. According to this definition, people are healthy even if they have suffered from a disease for a long time, but they can cope with life problems. Another definition of the health condition was provided by the WHO (1946): "the overall physical, mental and social well-being and not only mere absence of a disease or disability". This high-aimed ideal has been fiercely criticized, since, from this angle, people are unhealthy if they are unhappy or they fail to get personal or professional satisfaction (H.R. Blank, V. Burau, 2004, 52).

The problem of these definitions is that they do not consider all dimensions of the factors that enlarge the concept of health condition by including also quantitative data on quality of life. Because health has both an individual and a public dimension. Moreover, since health and illness have clear social and cultural influence, they should be viewed in a wide, general context of major determinants of the main health problems: (1) unfavourable socio-economic status; (2) sanitary habits relative to factors of health risks – smoking, drinking, improper feeding regime, drug addiction, physical non-activity (sedentary life); (3) poor environmental conditions, especially pollution (air, water, soil, etc.).

According to some authors (D. Callahan, 1990, 103), illness is both social and individual in all respects, since tolerability depends on the care and support provided by society (community). A good health needs social systems and networks which are not considered by the above-mentioned definitions.

The content and complexity of defining the health condition of the population do not help us very much to indicate what a health system is, where it begins and where it ends. In our paper we agree to the WHO official definition that the health system is "an assembly of activities with the essential aim of promoting, recovering and maintaining health" (WHO, 2000, p. 5). Considering this definition, the WHO establishes three fundamental objectives, "intrinsic" to health systems (WHO, 2000, p. 9):

- improving health for the population receiving such services → health improvement;
- meeting people's expectations → responsiveness;
- ensuring financial protection against the cost of poor health → financial equity.

2. Quality and equity: the importance of the performance of health systems

For assessing the performance of a health system, the WHO identified five dimensions (Box 1) to cope with the three intrinsic objectives (WHO, 2000, p. 29).

Box 1
Dimensions of the performance of a health system (WHO variant)

- **Health improvement**
  - general health condition
  - health distribution to the population
- **Responsiveness**
  - general degree of responsiveness
  - distribution of responsiveness
- **Financial equity**
  - distribution of financial equity

The WHO Report (2000) caused sharp debates, both in every country and worldwide, between experts. It is worth mentioning that ministers of health and their representatives generally agreed to the framework for assessing performance and selecting indicators. Generally, the WHO Report (2000) was considered an innovative performance assessing model that offers opportunities for further improvement (D. Baubeau, C. Pereira, 2004, p. 6). However, without blaming the Report, there were debates and critical comments basically focused on models used for assessing indicators, data reliability and the way of presenting the results. Moreover, the option for a single ranking of the countries based on a composite indicator of such a high level of aggregation is questionable (D. Baubeau, C. Pereira, 2004, p. 6) and many experts considered the WHO ranking (2000) to be discouraging and less suitable for improvement.

In spite of the above limits, the WHO Report (2000) helped to raise awareness of decision makers from all countries and put on their agenda the problem of ensuring performance within health systems and the need to create and consolidate national information systems. Also, the Report revealed – even if in a very brief from – the connections between various dimensions (including possible contradictory tensions), which hinders the measuring of indicators characterizing "performance".

The level of fulfilment of the fundamental objectives of a health system serves as reference for assessing the performance of national health systems, which, in turn, essentially depends on the extent to which health systems manage to fulfil the four vital functions:

- fulfilling health care tasks;

- creating human and material resources for rendering health services;
- collecting and managing resources for financing health services;
- ensuring general management, focused on promoting regulations and ensuring the strategic orientation of all people involved in producing and rendering services.

Within a health system, the stress is laid on the last function – general management, through the ministry in charge, that is, the Ministry of Health – for the reason that it considerably influences the other three functions. Physical integrity and dignity of man are recognized by international law, while national health systems are responsible for supervising whether people are treated with respect in accordance with human rights.

An individual seeking health care is a consumer, just as he is in case of other products and services, but he can also be a co-producer of his own health by observing adequate feeding, hygiene and physical exercise rules and applying, if necessary, medical prescriptions and other recommendations made by providers of health services. An individual also is a physical object to which all this care in directed. As regards the last aspect, we mention the importance of marketing, which is supposed to change the perspective of action and make public health services effective.

Thus, the implementation of marketing in the health services market should reveal the discrepancies between the population's health care needs and expectations, and the structures and the policies of health services in order to effectively allocate resources.

3. Responsiveness of health systems to patients' expectations: An important objective for achieving performance within health systems

This fundamental objective of a health system, that is, "responsiveness to patients' expectations", is not measured by the mode it meets health needs that occur in the results of medical assistance, but rather by the performance of the system in fields other than health and by its responsiveness to people's expectations as regards the way desire to be treated by providers of preventive, curing or collective health services.

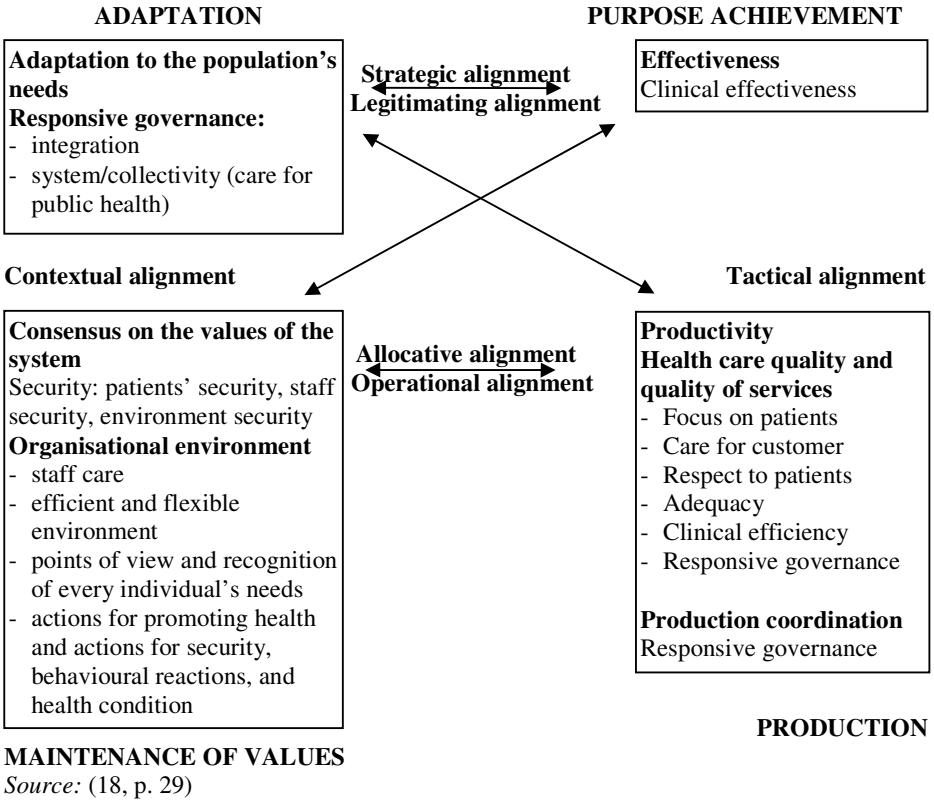
The general concept of responsiveness can be divided into several modes. In the World Health Report (2000, 33-36), the WHO makes a fundamental distinction between, on one hand, aspects concerning the respect to people, which are generally subjective and, first of all, judged by the patient, and, on the other hand, more objective aspects referring to the way a system responds to preoccupations frequently expressed by patients and their families in their capacity if customers of a system that they can directly observe in medical establishments. The WHO identifies seven categories:

(1) Respect to individuals includes:
- Respecting people's dignity. Generally, this rule means not to humiliate patients.
- Confidentiality or the patient's right to decide who is allowed access to data on his own health condition.
- Patient's autonomy, i.e., an opportunity for options concerning his own health, including the treatment to be administered.

(2) Attention paid to the customer, focused on the following:
- Quick consideration: immediate care in case of emergency and reasonable time for non-emergency cases.

- Satisfactory environment: adequate and spacious establishments, good food in hospitals.
- Access to networks of social support to patients (family and friends).
- Option for a provider, i.e., the possibility to opt for a person or an organisation to provide care.

The overall performance of a health system should be assessed from a perspective of an integrated system, which reveals the need for assessing performance with a view to the connections between its dimensions. In this respect, the European Regional Office of the WHO established an integrating model of assessment by taking into account all dimensions of performance. In the scheme of relations within this assessment model (Figure 1), one clearly identifies the impact of the quality of health care and services on productivity. Among the factors supporting the quality of health services, we also find elements that define the responsiveness of the health system to patients' expectations: focus on patients, care for patients and respect to patients.



Source: (18, p. 29)

Figure 1 The framework for assessing performance in integrating models

4. Marketing research for assessing the responsiveness of the Romanian health system

Generally, there are two questions regarding the performance of a health system: At what level a health system can ensure quality measures for rendering health services to improve the population's health? Is this level the same for all (equitable health services)? The answer can only be given by means of a system of relevant, adequate and competitive indicators, designed to support an effective management of a health system. Such a system of indicators for assessing the competitiveness of health systems includes also indicators of patients' satisfaction, which reveal the responsiveness to expectation.

To retain as a premise, it is worth mentioning that the use of data collected by research on site in the form of opinion surveys, aimed at how patients perceive the performance of the health system, should not be detached from the complex and multidisciplinary analysis of different quality levels, which converge to providing an overall picture of the performance of health systems in accordance with the paradigm of the integrating model of performance assessment suggested by the WHO (Figure 1).

In accordance with this premise, we should also analyse the results of the opinion survey of a patient sample.[1] The survey involved 1052 patients from six district capitals (Alba Iulia, Braşov, Galaţi, Râmnicu-Vâlcea, Târgovişte, Timişoara) and was aimed at assessing the responsiveness of the three forms of health care - primary, secondary and tertiary – to patients' expectations.

The size and structure of the patient sample by forms of health care – family doctor, polyclinic and hospital – were conditional on financial and human resources as well as on the time factor, within the limits of the estimated amounts of the research project. The sample includes units representative for the three types of health care in each district capital: town/district hospital, the largest polyclinic and, usually, family doctors assigned to this polyclinic. In selecting the six district capitals, we tried to ensure the distribution of the responsiveness of the health system on a territorial basis, including district capitals having both districtual health units and interdistrictual health units (the case of Timişoara). We also tried to include in the structure of the sample certain districts representative for administrative development regions (Centre – Alba Iulia and Braşov, South-East – Galaţi, South-West Oltenia – Vâlcea; South Muntenia – Dâmboviţa and West – Timiş).

The questionnaire (the tool used for the opinion survey of 1052 patients) provides a set of relevant data in order to assess some qualitative factors that influence the performance of health services.

Therefore, besides questions for defining the territorial coverage by health units surveyed and identifying the reason why a patient chooses a certain type of health care - primary (family doctor), secondary (polyclinic) and tertiary (hospital) - the questionnaire includes a question structured by elements that define the performance of health services in a health unit, distinctly by levels of assessment of the responsiveness of the three forms of health care to patients' expectations:

- Health care proper, the performance of which was measured on a five-stage scale between "very low/very unsatisfactory" and "very high/very satisfactory", based on six indicators of relevant power.

[1] *Made in the methodological context of the Excellence Research Project regarding "The optimization of the system for funding, producing and distributing health services to European citizens" (2005-2008), in which some authors of this paper were involved.*

- Respect to patients, materialized in respecting dignity (no humiliation), confidentiality (the patient's right to decide who is allowed access to data on his own health) and autonomy (the patient's possibility to take part in making options concerning his own health, including the treatment to be applied).
- Attention to the patient, measured by: the time provided for health care (in case of emergency on non-emergency), the quality of the environment, access to networks of social support to patients and to available specialized services.

a) **The performance level of health care proper** is shown by the average score computed by means of the marks on a scale from 1 (very low/very unsatisfactory) to 5 (very high/very satisfactory); this average score differs by categories of health units – family doctor, polyclinic, hospital – and municipalities included in the sample.

The average score, by total sample (1052 subjects), is usually above mark 4 (corresponding to a performance level tending towards "very satisfactory"). But the analysis of the score for each of the three categories of health units shows a less favourable position of polyclinics, since for three indicators of five the average mark is below four: the doctor's attention to the patient's problems (3.96), the doctor's attitude towards the patient's reasonable requests (3.92) and the technological level of the medical equipment (3.41).

One should note that, for all three types of organisation of health care, the average score of the indicator "technological level of the medical equipment" is around mark 3 (an average between high level and low level), which shows that the equipping of the Romanian health system still is below the population's expectations.

From a territorial perspective, there are differences in the performance of health care proper. The lowest ranked units are found in Alba Iulia and Târgovişte, with average scores below four for most of the performance indicators on all three stages of organisation of health care. In Braşov, the activity of polyclinic doctors is assessed as relatively low (Table 1).

Scores below 4, in the six municipalities, distributed by the three stages of organisation of health care

Tabel 1

	Alba Iulia	Braşov	Galaţi	Râmnicu-Vâlcea	Târgovişte	Timişoara
Family doctor						
• Patience to listen	-	-	-	-	3.94	-
• Doctor's attention to the patient's problems	3.93	-	-	-	3.88	3.84
• Doctor's attitude towards the patient's justified requests	3.76	-	-	-	3.69	3.84
• Technological level of medical equipment	2.69	3.84	3.92	-	2.88	-
Polyclinic						
• Doctor's professionalism	-	-	-	-	3.90	-

	Alba Iulia	Braşov	Galaţi	Râmnicu-Vâlcea	Târgovişte	Timişoara
• Patience to listen	-	-	-	-	3.74	-
• Doctor's attention to the patient's problems	-	3.65	-	-	3.32	-
• Doctor's attitude towards the patient's justified requests	3.98	3.71	-	-	2.93	-
• Technological level of medical equipment	2.85	2.90	3.67	3.00	3.86	-
Hospital						
• Doctor's attention to the patient's problems	3.63	-	-	-	-	-
• Doctor's attitude towards the patient's justified requests	3.80	3.70	3.55	3.48	3.79	-

b) Respect to the patient is a component of the definition of responsiveness of the health system to the patient's expectations.

An overall picture of the patient's perception of how he is respected by the doctor is provided by data presented in Table 2. The Municipality of Râmnicu-Vâlcea, showing a very high proportion (95.3%-98%) of patients satisfied with the doctor's respect, differs significantly from the Municipality of Alba Iulia, which holds the opposite position, i.e., the lowest proportion of satisfied patients (65.5%-83%).

The proportion of interviewed persons satisfied with the treatment provided by doctors

Table 2

Indicator of the patient's perception of the respect	Interviewed persons considering that the patient is respected, per cent of the total sample for each municipality					
	Alba Iulia	Braşov	Galaţi	Râmnicu-Vâlcea	Târgovişte	Timişoara
• Respecting dignity	71.5	92.8	87.4	98.0	89.2	72.3
• Confidentiality	83.0	87.7	74.3	97.3	86.0	79.5
• Autonomy	65.5	78.5	78.1	95.3	68.1	78.3

c) The attention paid to the patient is the third component that defines the responsiveness of the health system to the population's expectations.

The overall picture provided after processing the answers from 1052 interviewed people (Table 3) shows that the quality of health services is relatively improper in relation to the population's expectations.

The proportion of interviewed persons who appreciate positively the attention received from health units

Table 3

Indicator of the patient's perceptin of the respect	Interviewed persons who appreciate positively ("yes") the attention paid to the patient, per cent of the total sample for each municipality					
	Alba Iulia	**Braşov**	**Galaţi**	**Râmnicu-Vâlcea**	**Târgovişte**	**Timişoara**
1. Time for medical assistance - fast, in case of emergency	77.5	75.7	56.8	83.3	61.6	92.8
- reasonable, in case of non-emergency	70.0	83.3	71.0	77.3	82.2	57.8
2. Quality of the environment - rooms/wards are clean	84.0	70.1	67.8	94.0	87.0	81.9
- toilets are clean	60.5	67.7	43.2	60.0	68.1	65.1
- food is good (in hospital)	61.1	56.9	45.8	90.9	53.3	67.4
3. Access to social support networks (in case of patients facing risk factors: alcoholism, drugs, handicap)	30.0	41.0	29.5	86.0	14.1	39.8
4. Access to available specialized services	66.0	83.3	77.6	89.3	68.9	60.2

Table 3 shows the weaknesses of the attention paid to the patient:

- Low quality of the environment, indicated by a high proportion of negative appreciation concerning the following: cleanliness of toilets (57% in Galaţi, 40% in Râmnicu-Vâlcea and Alba Iulia, 35% in Timişoara, 32% in Braşov and Târgovişte), food quality in hospitals (54% in Galaţi, 47% in Târgovişte, 43% in Braşov, 39% in Alba Iulia, 33% in Timişoara), cleanliness of rooms/wards (32% in Galaţi, 30% in Braşov, 18% in Timişoara, 16% in Alba Iulia, 13% in Târgovişte).
- Time for medical assistance, relatively non-corresponding to expectations even in case of emergency: the proportion of interviewed persons who consider that in case of emergency there is no quick answer to the patient's request: 43% in Galaţi, 38% in Târgovişte, 25% in Braşov, 23% in Alba Iulia, 17% in Râmnicu-Vâlcea.
- The access to available specialized services still is improper: the proportion of interviewed persons who gave negative answers is 40% in Timişoara, 34% in Alba Iulia, 31% in Târgovişte, 23% in Galaţi, 17% in Braşov.

Conclusions

The analysis of the results of the opinion survey reveals - as a general trend in the total sample (1052 patients) – a high responsiveness of the three forms of health care that does not thoroughly meet the patients' expectations; the patients are most dissatisfied with: poor quality of the environment; cleanliness of toilets; food quality in hospitals; cleanliness of rooms/wards. At the same time, there are dysfunctions regarding the following: the time for medical assistance is relatively below expectations, even in case of emergency; still inadequate access to available specialized services. In many cases (but mainly in hospitals), the doctor's attitude towards the patient's justified requests is improper (usually, marks below 4, corresponding to "high/satisfactory ranking").

This responsiveness of the three forms of health care to the patients' expectations should be correlated with the impact produced by determinants of the population's health condition. It is worth mentioning that the sample structure confirms the fact that the prevalence of unfavoured segments (pensioners, workers, old people) with a low education level, explains to some extent the high score, since these segments of patients tend to give higher marks, far from the actual quality of health care provided.

The health condition of an individual is based on two pillars that help to improve performance in providing health care. It refers, on one hand, to the health care system proper and, on the other hand, to health determinants: social and physical environment, socio-economic level, education level or the living standard. In this respect, it is quite sure that the analysis of the performance of national health systems cannot be fully and easily made because of problems that hinder an assessment of results and the separation of the contribution of the health system from other determinants of the health condition of an individual; for example, the improvement of the environment and the living standard, which define or support health maintenance and illness prevention.

The measurement of the health system performance has significant practical effects, due to the pressure exerted by the public and the financial constraints that affect now the national health system. Therefore, the assessment of the performance of a national health system should be equally considered:

- a justified action, supported by public aspirations for a better health system and a higher responsibility of this system;
- a difficult action, dependent on the complexity of health determinants and the multitude of interventions (actors) in the production, distribution and funding of health services;
- a political action, because the expected performance depends on objectives established by public powers and the citizens' expectations for a health system.

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